

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 2  
2-45  
7-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAY 16 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **17840**  
Registrar's No. **66**

Registration District No. **155** Primary Registration District No. **3127**

**1. PLACE OF DEATH:**  
(a) County Jasper  
(b) City or town Webb City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Jane Chinn Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution SEVEN DAYS  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Mrs. Mildred Thurlo Highley  
3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Samuel Highley 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased March 2, 1929  
(Month) (Day) (Year)

**8. AGE:** Years 18 Months 1 Days 28 If less than one day hr. min.

9. Birthplace Lynn County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business

**MOTHER FATHER**  
12. Name Mason Thurlo  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Dorothy Morris  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mason Thurlo  
(b) Address Webb City, Mo.

17. (a) Burial (b) Date thereof 5/3/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery  
18. (a) Signature of funeral director Heide-Lewis  
(b) Address Webb City, Mo.

19. (a) MAY 3; 47 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Jasper  
(c) City or town Webb City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 714 South Madison  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month April day 30  
year 1947 hour 6:20 minute A. M.  
21. I hereby certify that I attended the deceased from APR. 16; 47, 19, to APR. 30; 1947, 19, that I last saw her alive on 4-30, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death  
Tuberculous meningitis  
due to General Peritonitis  
due to Tuberculous Peritonitis  
Other conditions (Include pregnancy within 3 months of death)

Duration  
4 days  
2 days  
4 weeks

Major findings: Abscess of Rt. tuberculous  
Of operations Supplemental  
Of autopsy Information  
**139**  
**SUPPLEMENTAL INFORMATION REQUESTED**

**22. If death was due to external causes, fill in the following:**  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)  
While at work? Office (c) Means of injury 2  
23. Signature [Signature] (M. D. or other) Do  
Address Webb City, Mo. Date signed 4-30-47

47-4-399

*Gregory*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*E. M. Hedge*

Licensed Embalmer No. ....

*28159*

P. O. Address.....

*Cleveland, Ohio*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jaeger  
(b) City or town Webb City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jaeger  
(c) City or town Webb City  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mildred Highley

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or br 6. (a) Single, widowed, married, divorced Mar.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased man 2 (Month) (Day) (Year)

8. AGE: Years 18 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, \_\_\_\_\_ min.)

9. Birthplace \_\_\_\_\_ (City, town or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 30, year 1947 day \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to General Peritonitis

Due to Tuberculosis - Gonorrhea in organ

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature M Highley (M: D. or other) \_\_\_\_\_

Address Webb City, Mo. Date signed 7-9-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

